

Smoking Cessation:

Integrated Care Model for Smokers with PTSD

Presented by

National Center for PTSD

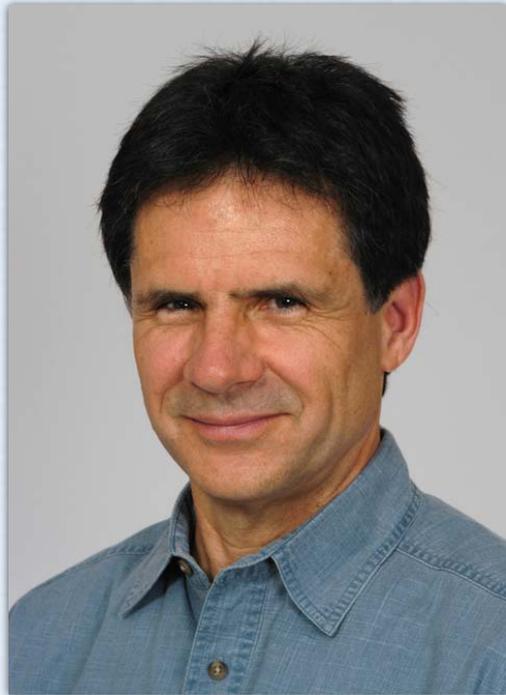
U.S. Department of
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National
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Posttraumatic
Stress Disorder



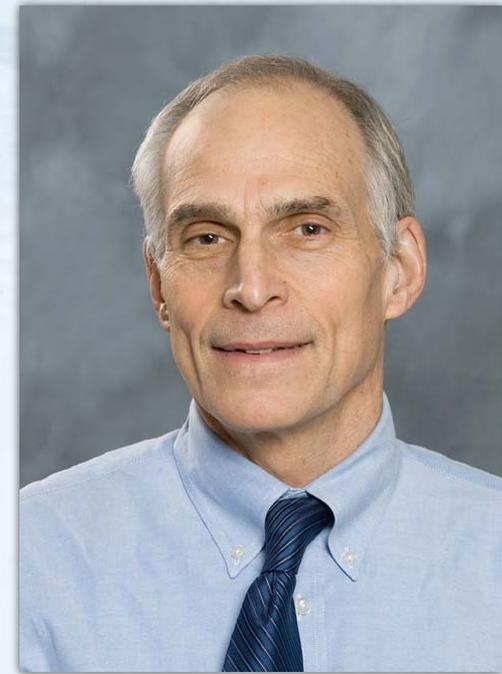
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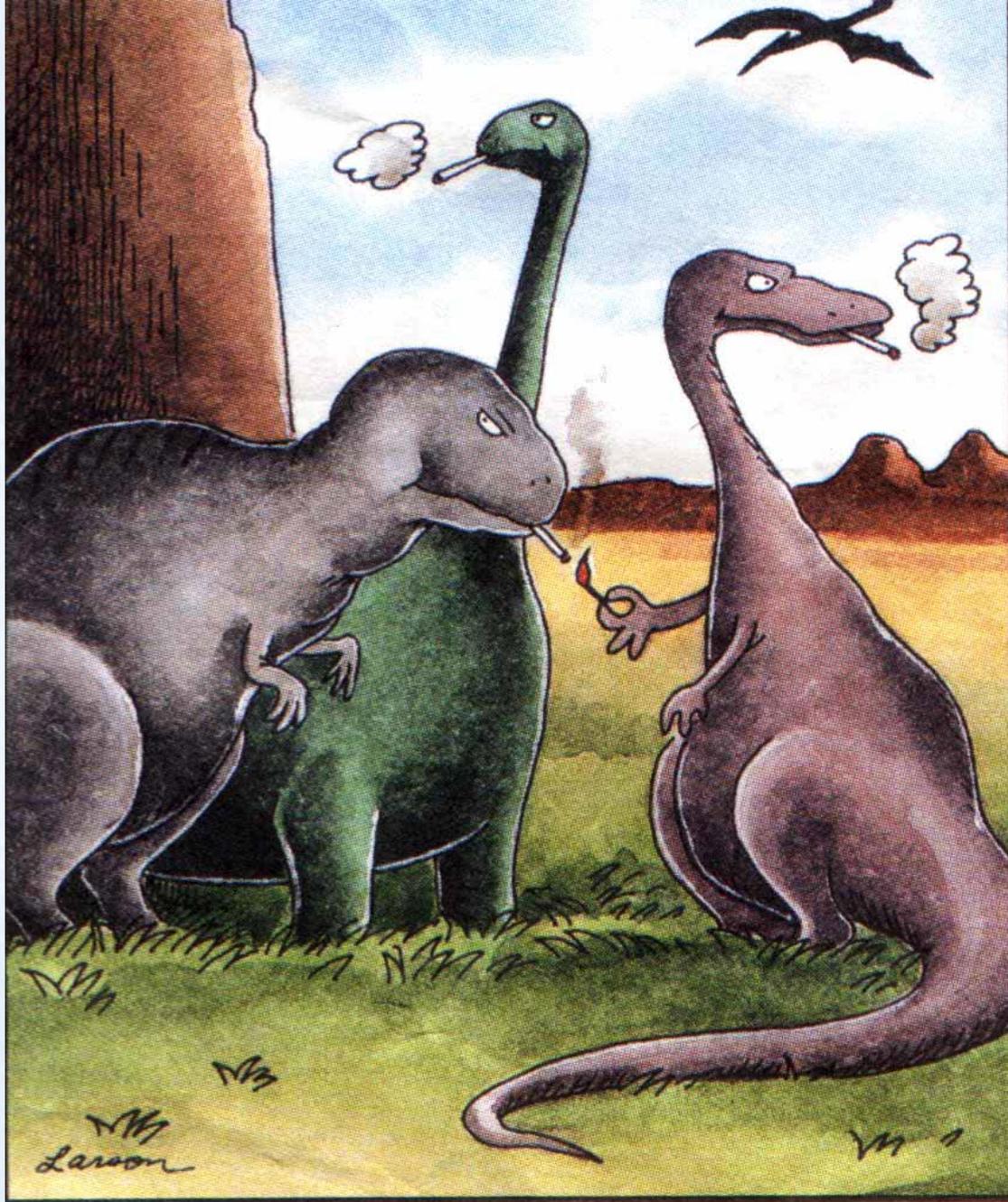
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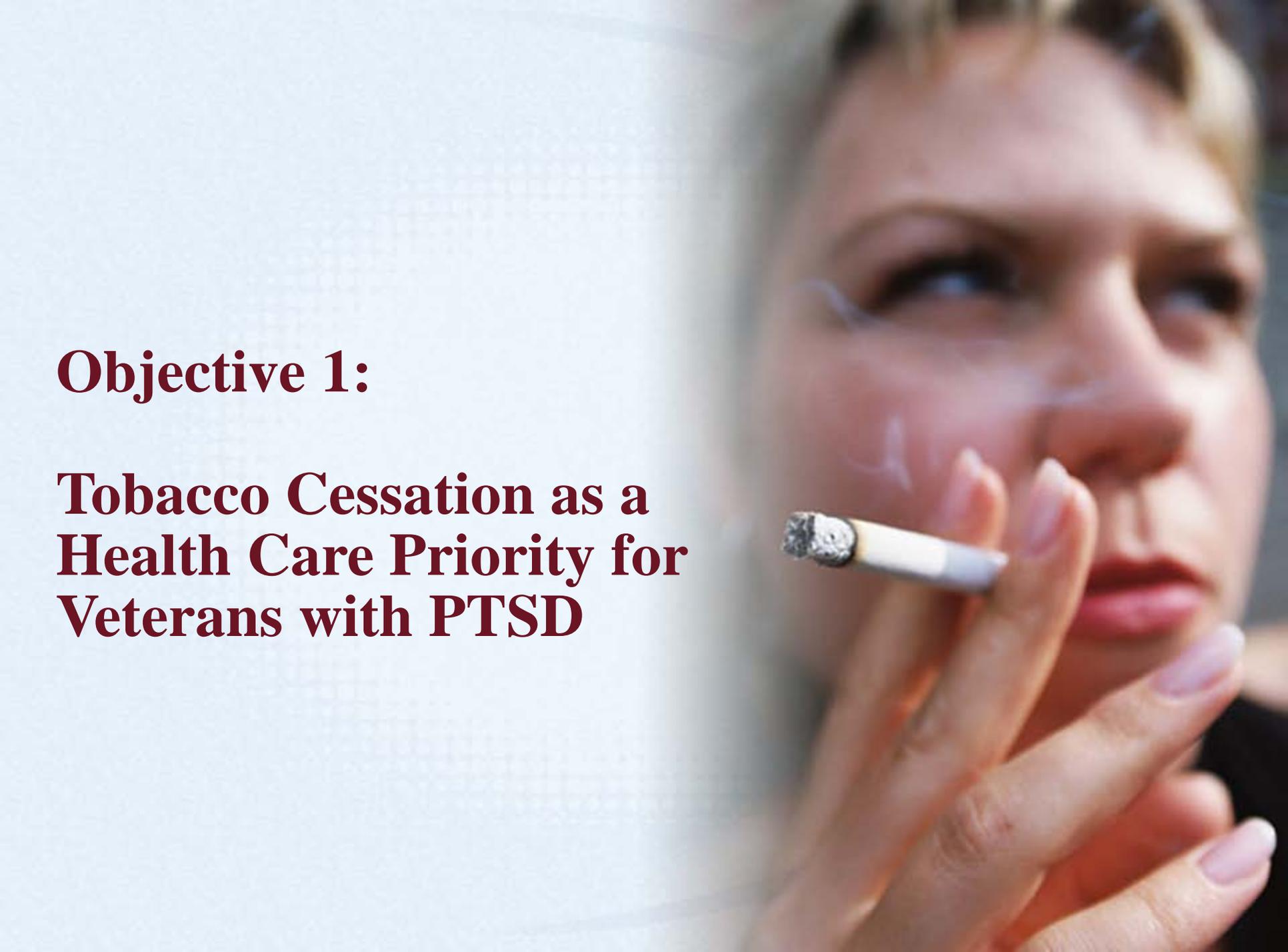
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Objectives

- 1.** Provide a rationale for tobacco cessation as a health care priority for Veterans with PTSD
- 2.** Review the rationale and evidence of an integrated care approach for smoking cessation among smokers with PTSD
- 3.** Provide an overview of interventions



The real reason dinosaurs became extinct



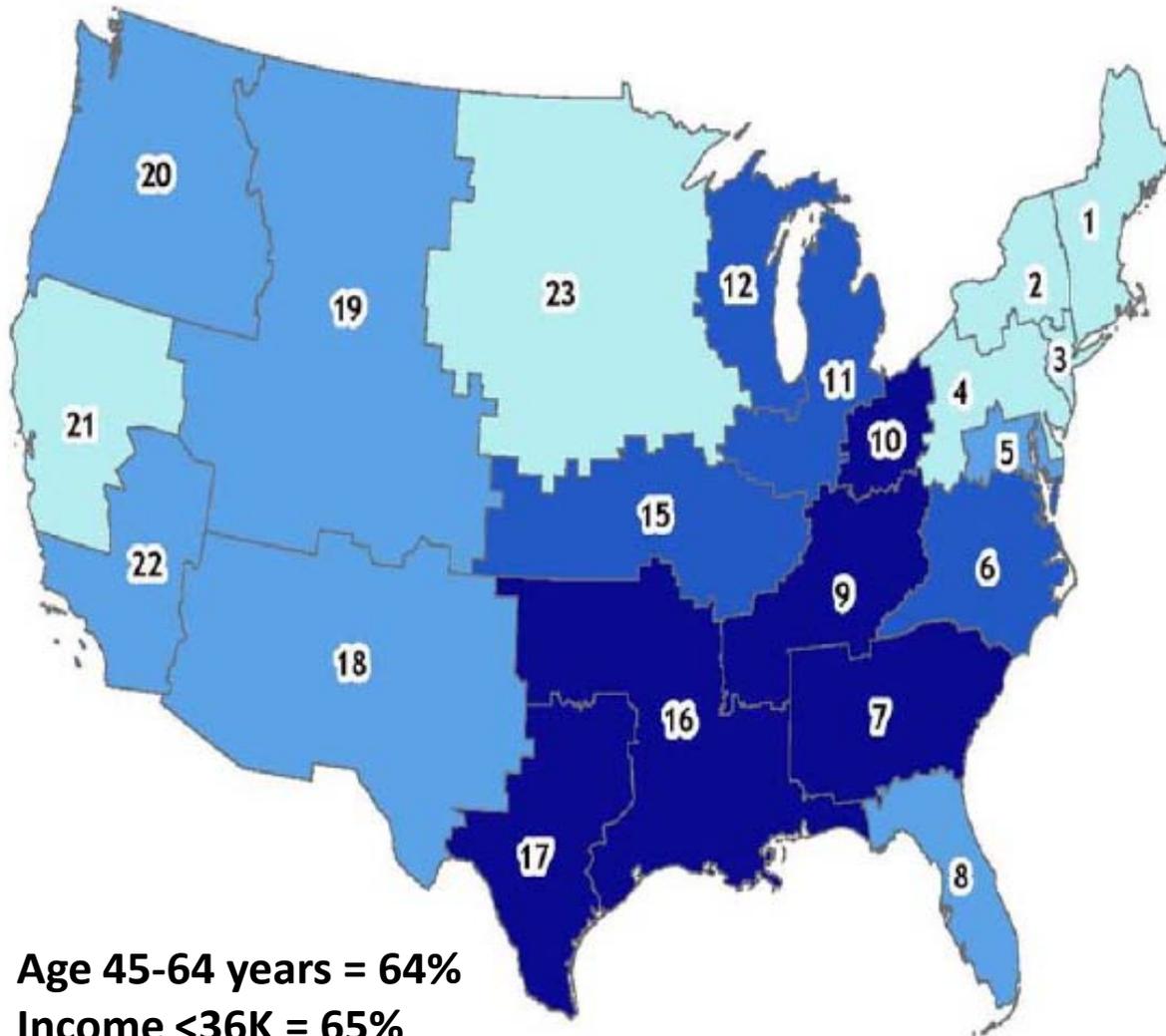
Objective 1:

**Tobacco Cessation as a
Health Care Priority for
Veterans with PTSD**

Tobacco Dependence Disorder: A Public Health Problem

- ▶ Most preventable cause of morbidity and mortality in the U.S.
- ▶ 33%-45% of smokers will die from tobacco-related illnesses
- ▶ Accounts for 20% of all deaths annually (440,000)
- ▶ Life expectancy shortened 13.2 years for males and 14.5 years for females
- ▶ Most lethal substance use disorder
 - 4x more deaths from tobacco than alcohol use

2007 Current Smokers in VA



Legend



VISN	Current Smokers	Enrollees	Percent Smokers
1	56,642	315,822	17.9%
2	36,680	201,504	18.2%
3	53,237	320,694	16.6%
4	74,538	427,286	17.4%
5	32,961	168,209	19.6%
6	87,825	376,952	23.3%
7	108,889	425,147	25.6%
8	118,564	599,310	19.8%
9	88,038	334,936	26.3%
10	70,463	263,074	26.8%
11	69,261	314,297	22.0%
12	76,800	321,447	23.9%
15	71,258	294,006	24.2%
16	152,268	601,804	25.3%
17	84,960	335,834	25.3%
18	58,757	289,712	20.3%
19	44,018	212,742	20.7%
20	67,249	325,281	20.7%
21	55,152	305,042	18.1%
22	78,721	382,159	20.6%
23	61,476	371,689	16.5%
National	1,547,757	7,186,950	21.5%

Age 45-64 years = 64%
Income <36K = 65%

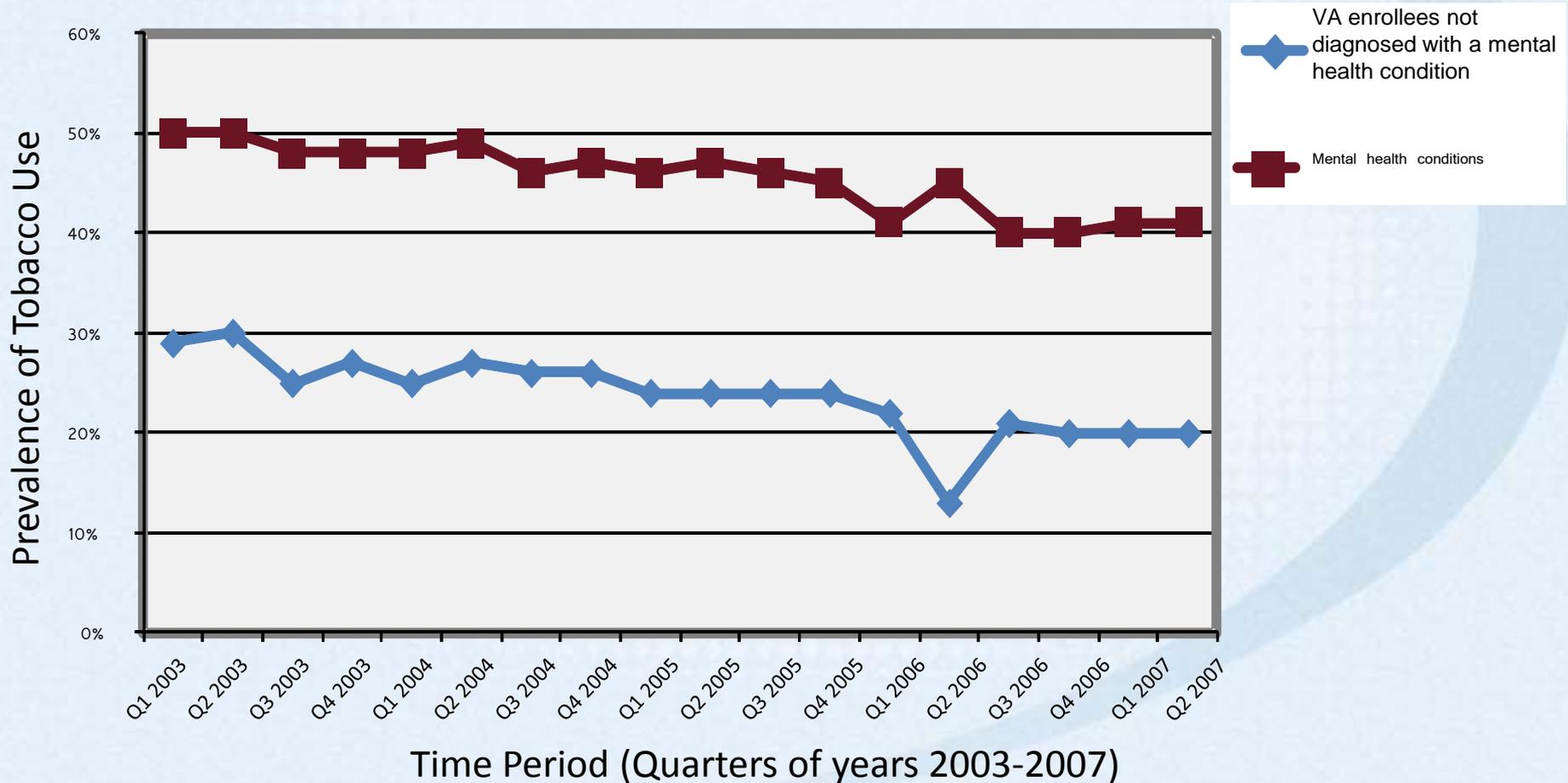
Source: 2007 Survey of Enrollees
Health and Reliance in VA

Tobacco Use and Mental Illness

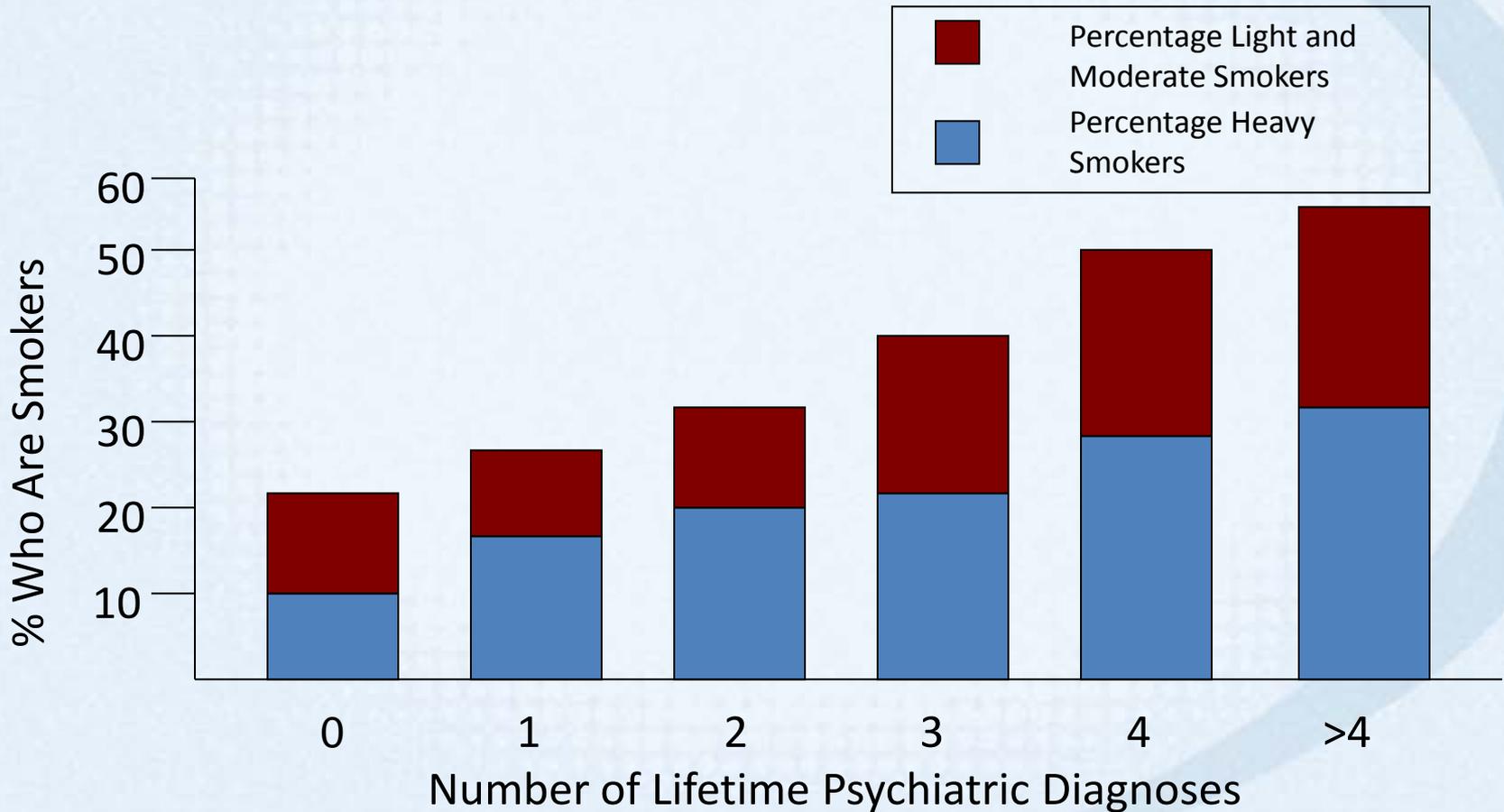
- High prevalence of smoking in people with serious mental illness (50%) compared to general population (21%)
- Persons with mental illness smoke half of all cigarettes produced
- Smoking quit-rates for the mentally ill are half the quit-rates of smokers without mental disorder
- Smoking-related diseases and mortality are disproportionately high for Veterans with mental disorders

Smoking Rates of Veterans Receiving VA Care

VHA National Tobacco Use
(Office of Quality and Performance/EPRP)



Smoking Rates by Number of Lifetime Mental Health Diagnoses





LUIS SINCO / *Los Angeles Times* 2004





A Threat Within: Tracking the Deadly Ambitions of Najibullah Zazi

TIME

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In Afghanistan
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Why Nation-
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BY PETER BERGEN
Why It Won't
BY LESLIE H. GELB

Sgt. First Class
Chet Millard
awaiting medevac
helicopters in
Wardak province,
Afghanistan,
on Sept. 8



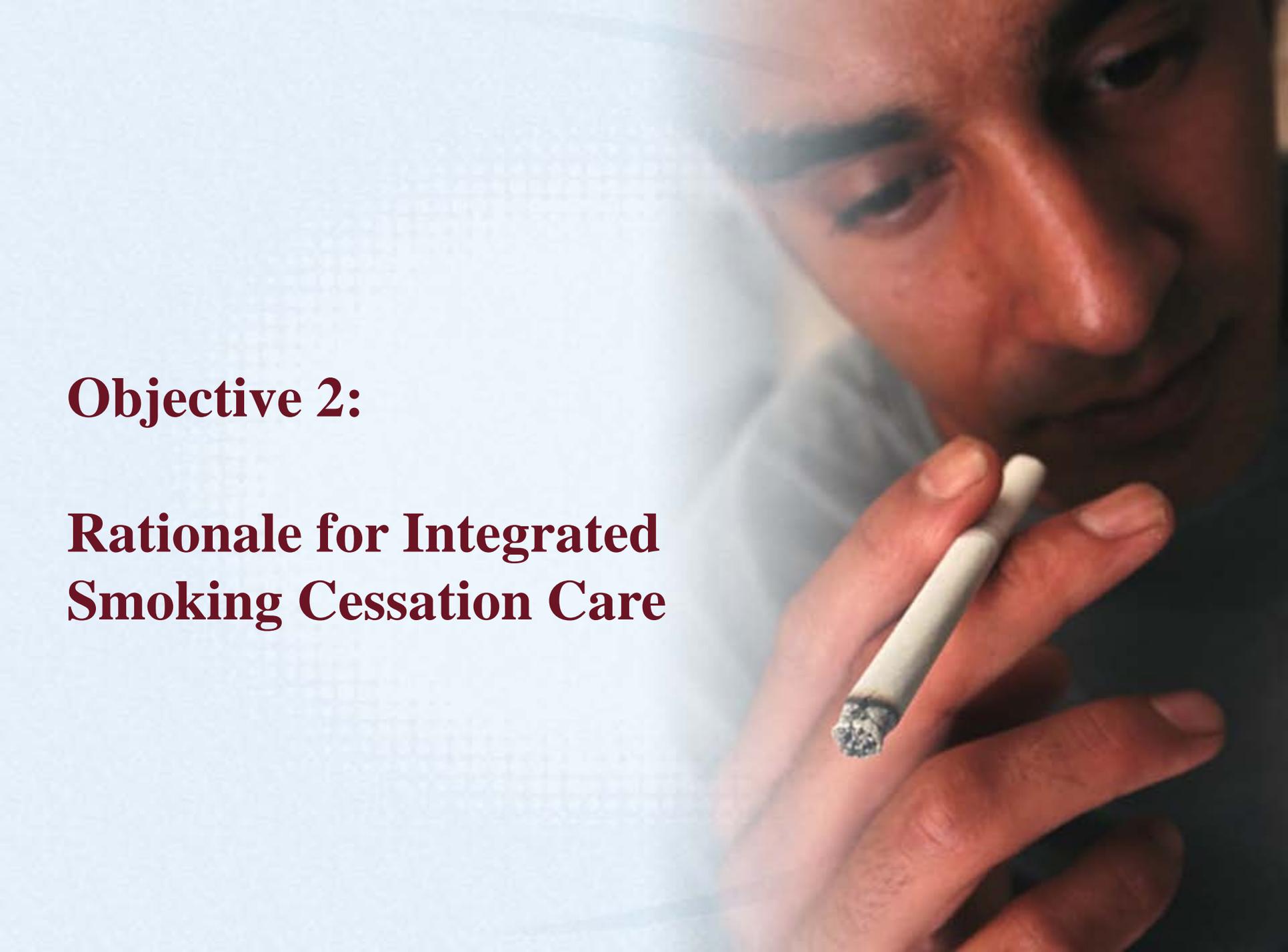
Tobacco Use and PTSD

- ▶ Prevalence of smoking in community samples with PTSD is 45%
- ▶ 30% - 50% of VHA patients with PTSD smoke
- ▶ PTSD increases risk for smoking four-fold
- ▶ More Veterans with PTSD are heavy smokers (48%), compared to Veterans without PTSD (28%)
- ▶ Smoking quit-rates for PTSD are among the lowest in persons with mental disorders
- ▶ Tobacco use contributes to morbidity, health care costs, and premature mortality

Implications for Treatment

- ▶ PTSD smokers as committed to and interested in quitting smoking as those without PTSD
- ▶ PTSD smokers likely need additional assistance and multiple quit attempts
- ▶ Reduction of PTSD symptoms and implementation of mood management strategies are important





Objective 2:

**Rationale for Integrated
Smoking Cessation Care**

“Good News” for VHA Tobacco Control

- ▶ Efficacious pharmacological and counseling treatments exist (20% - 25% success rates)
- ▶ 60% of VA enrollees who smoke want to quit and are receptive to treatment
- ▶ Clinical practice guidelines for tobacco cessation treatment in primary care exist
- ▶ Smoking clinic settings are available
- ▶ Performance measures require clinicians to screen and offer cessation treatment

Tobacco Cessation Treatment Delivery

1. Refer to smoking cessation program
2. Treat within primary care
3. Refer to telephone quit-line counseling
4. Treat within mental health care



Service Delivery: *Specialized Smoking Cessation Clinics*

88% of VA smokers who receive care obtain that care in specialized smoking cessation clinics

► Advantage

- Clinics provide comprehensive, intensive tobacco cessation treatment

► Disadvantage

- Failure to show for initial session = 48% - 87%
- Dropout rates = 44% - 79%

Service Delivery: *Primary Care Providers*

- ▶ Of VA smokers receiving cessation treatment:
 - 12% obtain this treatment from a primary care provider
 - 31% obtain it from a primary care provider plus smoking cessation clinic
- ▶ VA primary care providers screen patients for tobacco use (98%), advise smokers to quit (95%), and inquire about interest in treatment (76%)
- ▶ Actual delivery of tobacco cessation treatments to smokers, particularly those with mental illness, are low
- ▶ Psychiatrists provide cessation counseling in only 12% of visits

Service Delivery in VHA: *How Well Does it Work?*

Only 17% - 22% of VA
enrollees who smoke and
who want to quit report
receiving desired cessation
treatment in prior year¹



“Our lack of progress in tobacco control is more the result of failure to implement proven strategies than the lack of knowledge about what to do.”

— David Satcher, M.D., Ph.D., Surgeon

General

Barriers to Effective Service Delivery

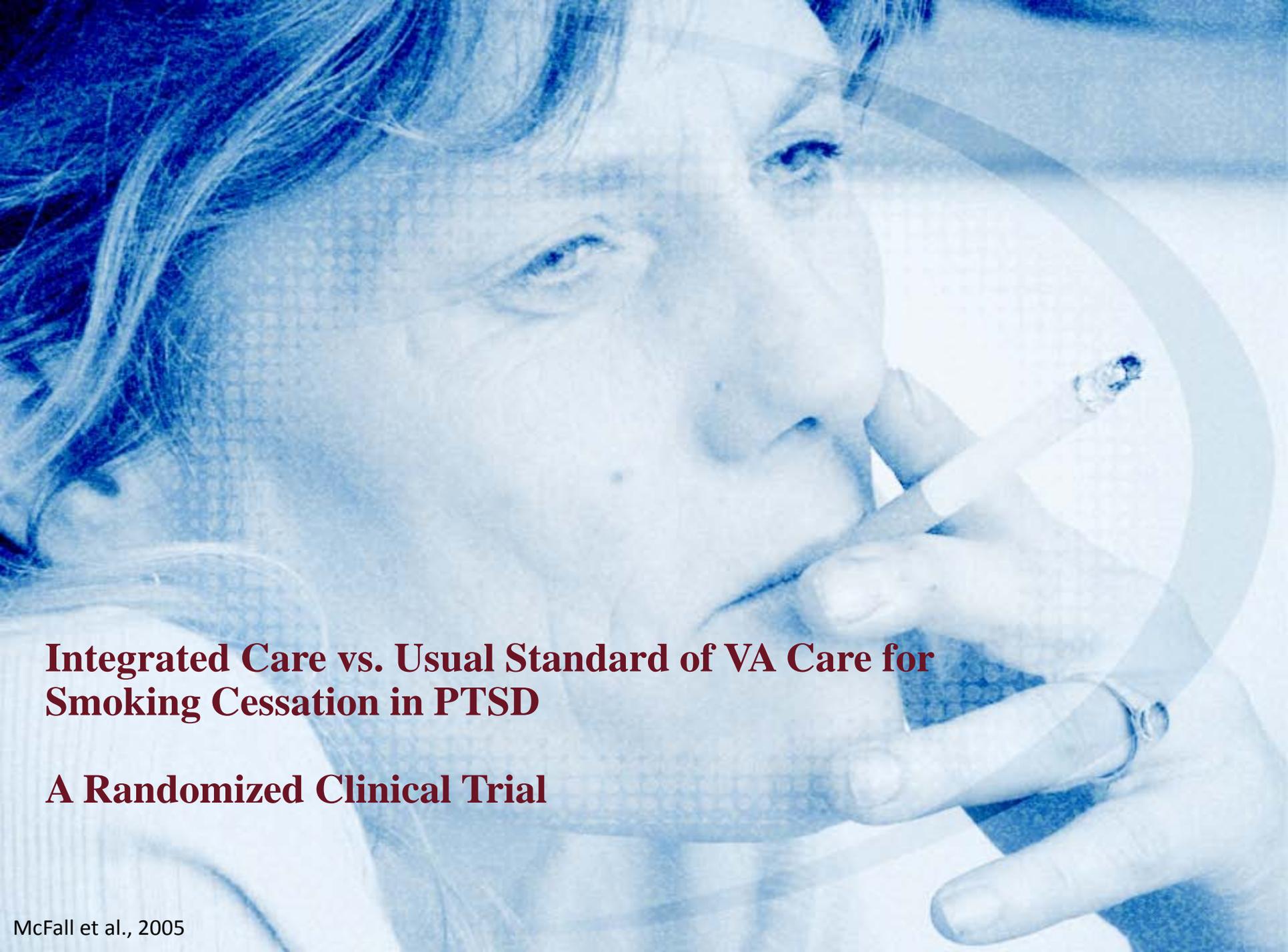
- Brief, episodic tobacco cessation treatments are no match for nicotine dependence
- Limited provider time for repeated monitoring
- Insufficient training in cessation treatment
- Limited time/training to address smoking complicated by PTSD
- Limited resources
- Provider beliefs that cessation treatment is ineffective

Rationale for Integrating Smoking Cessation Treatment Into Mental Health Care for PTSD

- ▶ Providers have advanced training in treating behavioral and substance use disorders
- ▶ Providers can tailor cessation treatment to address the dynamic interaction of tobacco use with psychiatric symptoms
- ▶ The frequent, continuous nature of mental health care
- ▶ Mental health clinics expand access to smoking cessation treatment for underserved and overcome barriers to care

Goals of Integrated Care

- Create a clinic culture prioritizing tobacco cessation care as a core responsibility of PTSD program providers
- Assess and treat tobacco use disorder in all willing patients undergoing mental health treatment
- All mental health providers embrace tobacco cessation as part of their job
- Provide brief and/or intensive interventions on repeated occasions to Veterans who smoke, in multiple settings

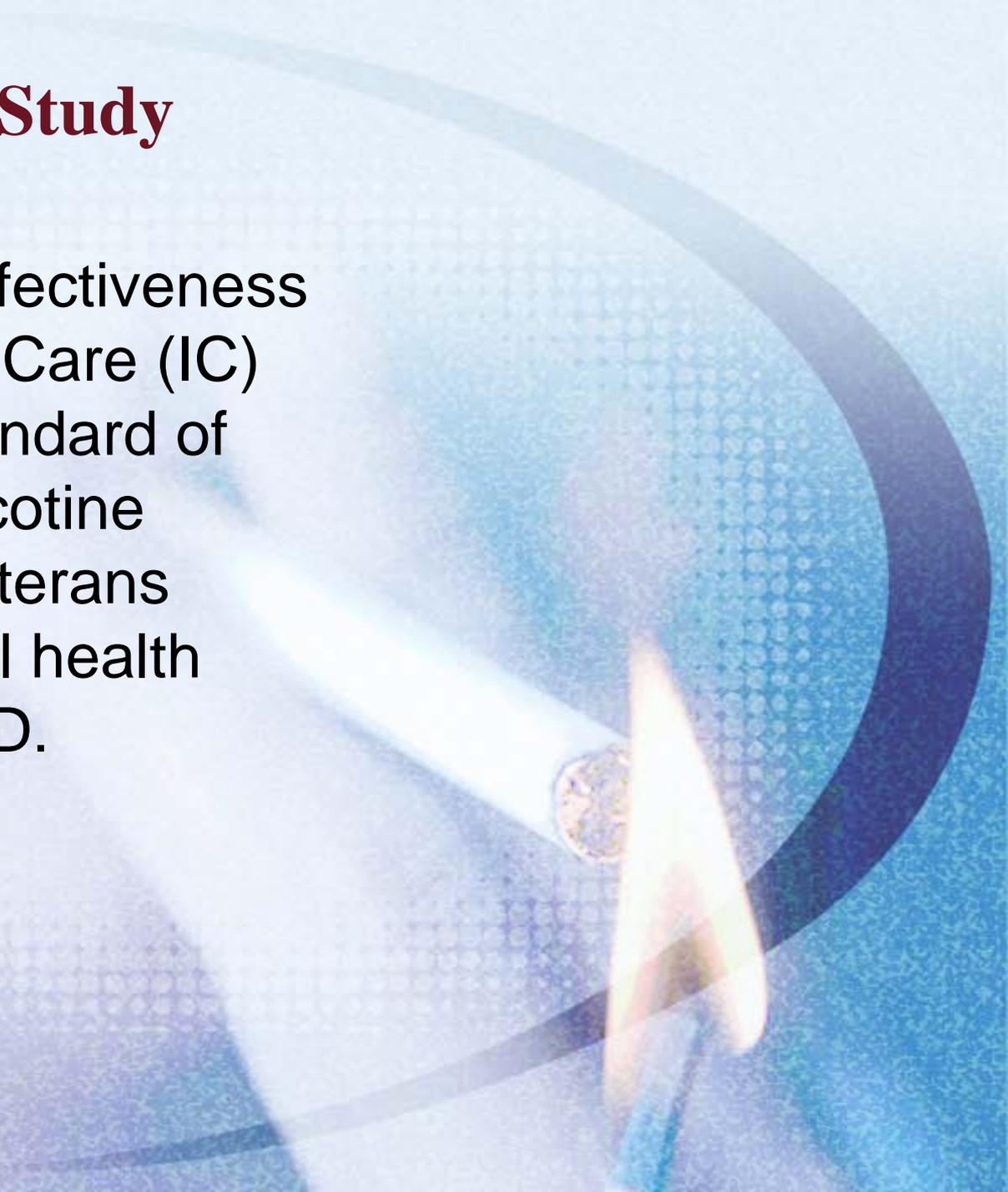


**Integrated Care vs. Usual Standard of VA Care for
Smoking Cessation in PTSD**

A Randomized Clinical Trial

Objective of the Study

To compare the effectiveness of brief Integrated Care (IC) vs. VA's Usual Standard of Care (USC) for nicotine dependence in Veterans undergoing mental health treatment for PTSD.



Study Design and Eligibility Criteria

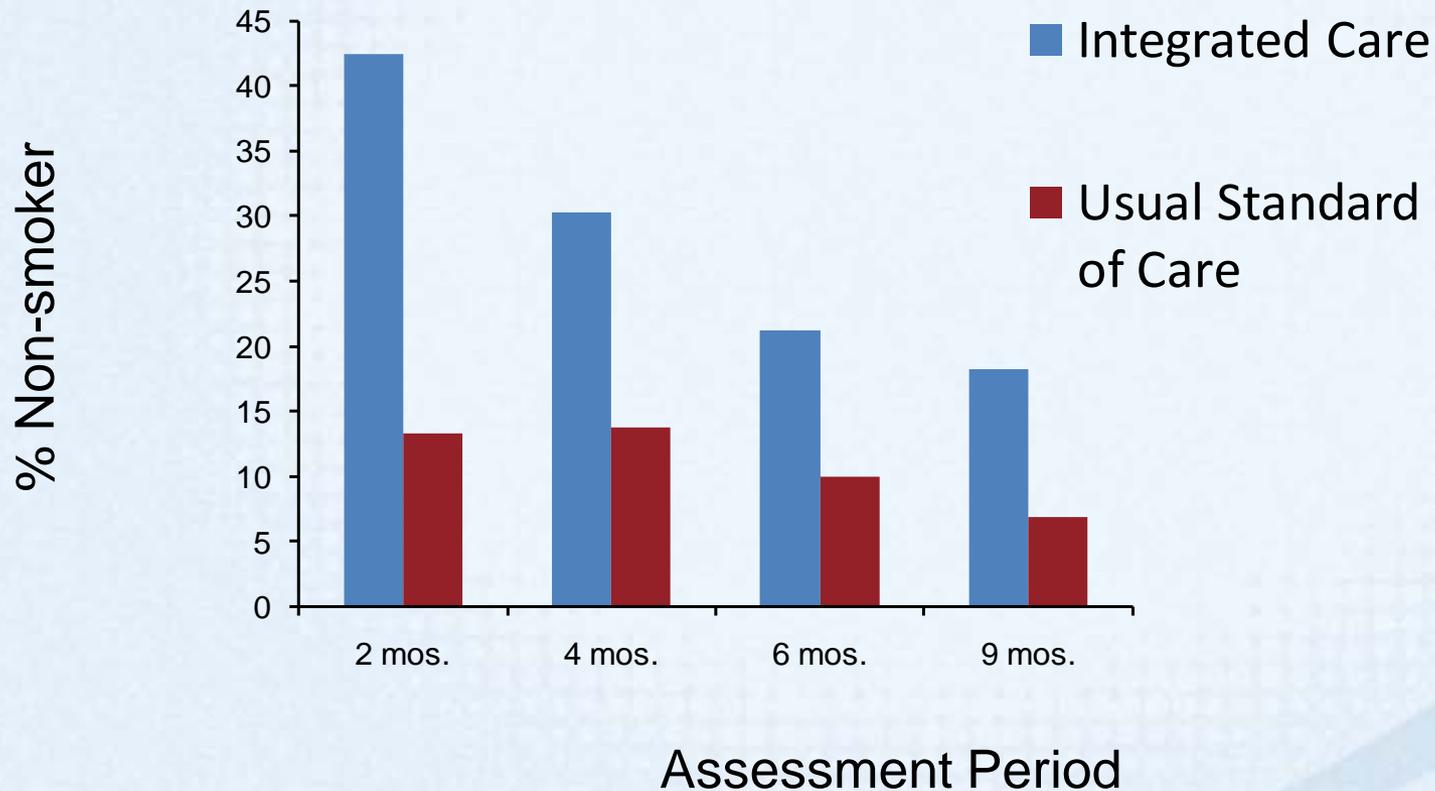
Design:

- Two-group randomized, controlled effectiveness trial comparing IC ($n = 33$) vs. USC ($n = 33$)

Participants:

- 5 women and 61 men
- Average age = 53 years
- Smoked > 10 cigarettes per day
- Patients with unstable psychosis or borderline personality disorder, untreated substance dependence, or who were using smokeless tobacco were not included

Clinical Outcomes: 7 Day Non-Smoking Status



Odds Ratio = 5.23, $p < .0014$

Clinical Outcomes: Process Variables

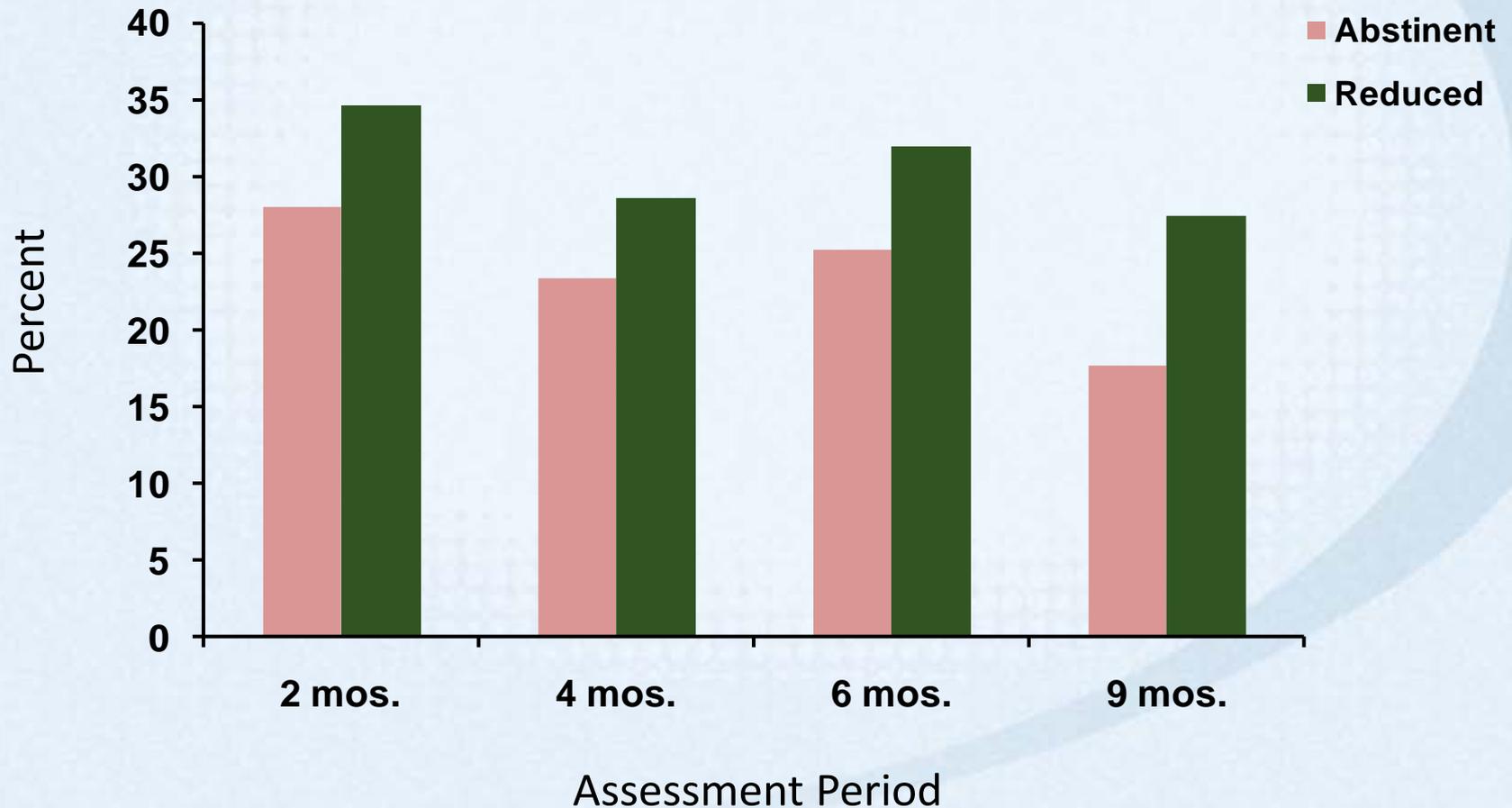
Variable	Integrated Care	Usual Standard of Care
Bupropion SR	61%	48%
Transdermal Nicotine*	94%	67%
Nicotine Gum*	88%	42%
Treatment Sessions*	5.2	2.6
Quit Attempts	4.29	3.25
Satisfaction with Amount of Treatment*	3.9 (1-5 scale)	3.5
Satisfaction with Quality of Treatment*	3.7 (1-5 scale)	3.4

Practice-Based IC for Smoking Cessation:

An Open Clinical Trial

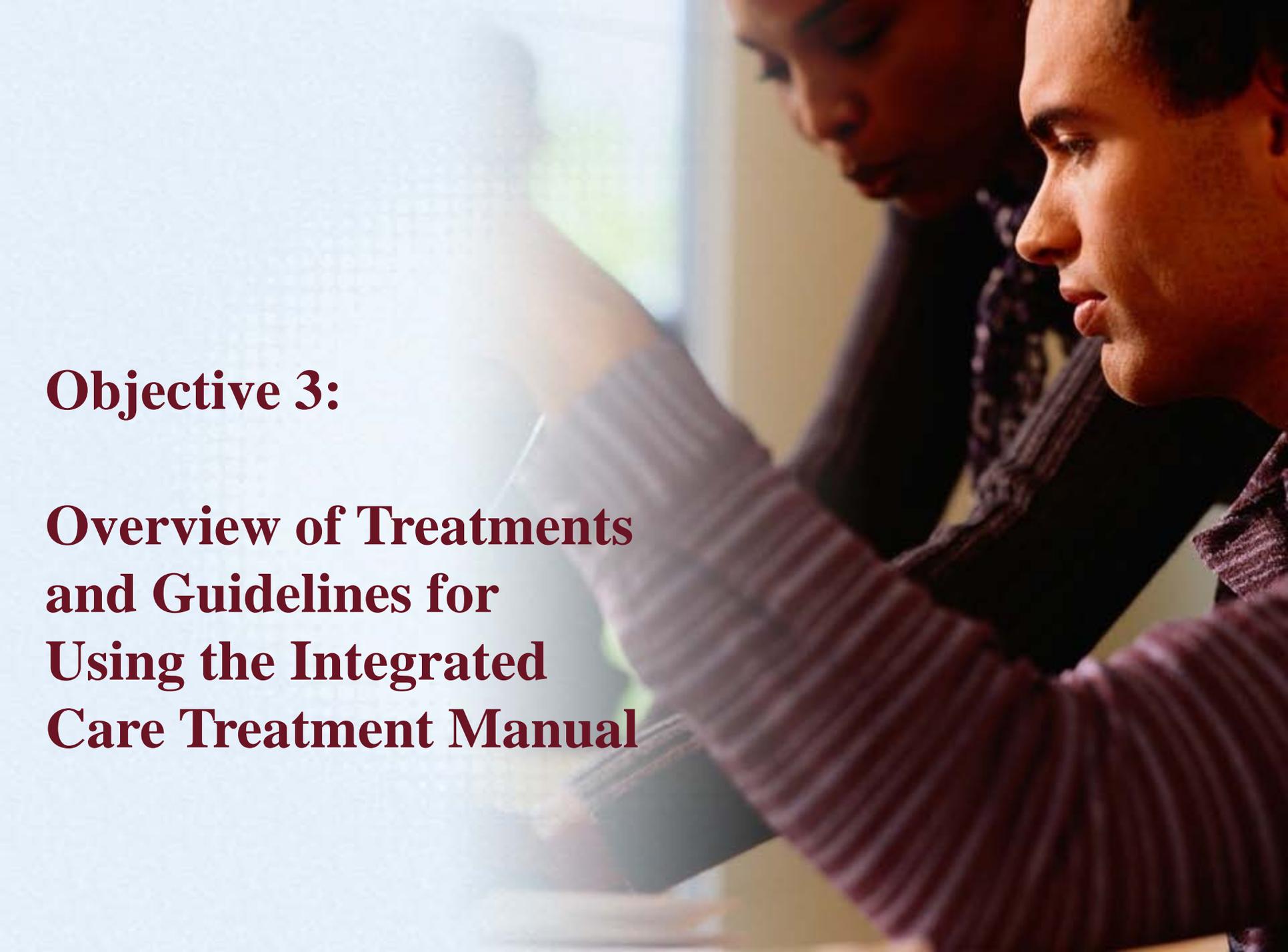


7-Day Point Prevalence Abstinence and Percent Reduction for Continued Smokers ($n = 107$)



Conclusions from Preliminary Work

- ▶ It is feasible to incorporate guideline-based smoking cessation treatment into routine delivery of mental health care for PTSD
- ▶ Integrating treatment of nicotine dependence is more effective than the usual standard of VA care for PTSD patients
- ▶ IC was a better vehicle than USC for delivering cessation treatments of sufficient intensity, which may explain the superior results of IC



Objective 3:

Overview of Treatments and Guidelines for Using the Integrated Care Treatment Manual

Integrated Care Treatment

- ▶ Guideline-based, manualized, individual treatment
- ▶ Core interventions
 - Behavioral counseling (five sessions totaling ~120 min.)
 - Pharmacotherapy
 - Patient manual
- ▶ Relapse prevention and management
 - Booster sessions monthly
 - Encouragement for multiple quit attempts

Who Should Provide Treatment?

Primary mental health provider

- ▶ Primary point of contact for patient who coordinates his/her overall mental health care
- ▶ Ongoing, continuous contact and familiar relationship
- ▶ Ability to monitor, detect, and respond to relapses over time
- ▶ All members of mental health team should be able to provide treatment to their patients

Treatment Modality

Individual treatment modality

- Incorporated into regularly scheduled individual therapy sessions
- Separate individual visits for patients primarily seen in group
- Face-to-face visits for five core skills acquisition sessions take place within scheduled visit
- Follow-up visits optimally provided in face-to-face format, but phone delivery acceptable if necessary

Structure and Organization of the Behavioral Provider Treatment Manual

Integrating Smoking Cessation Treatment
into Mental Health Care for PTSD

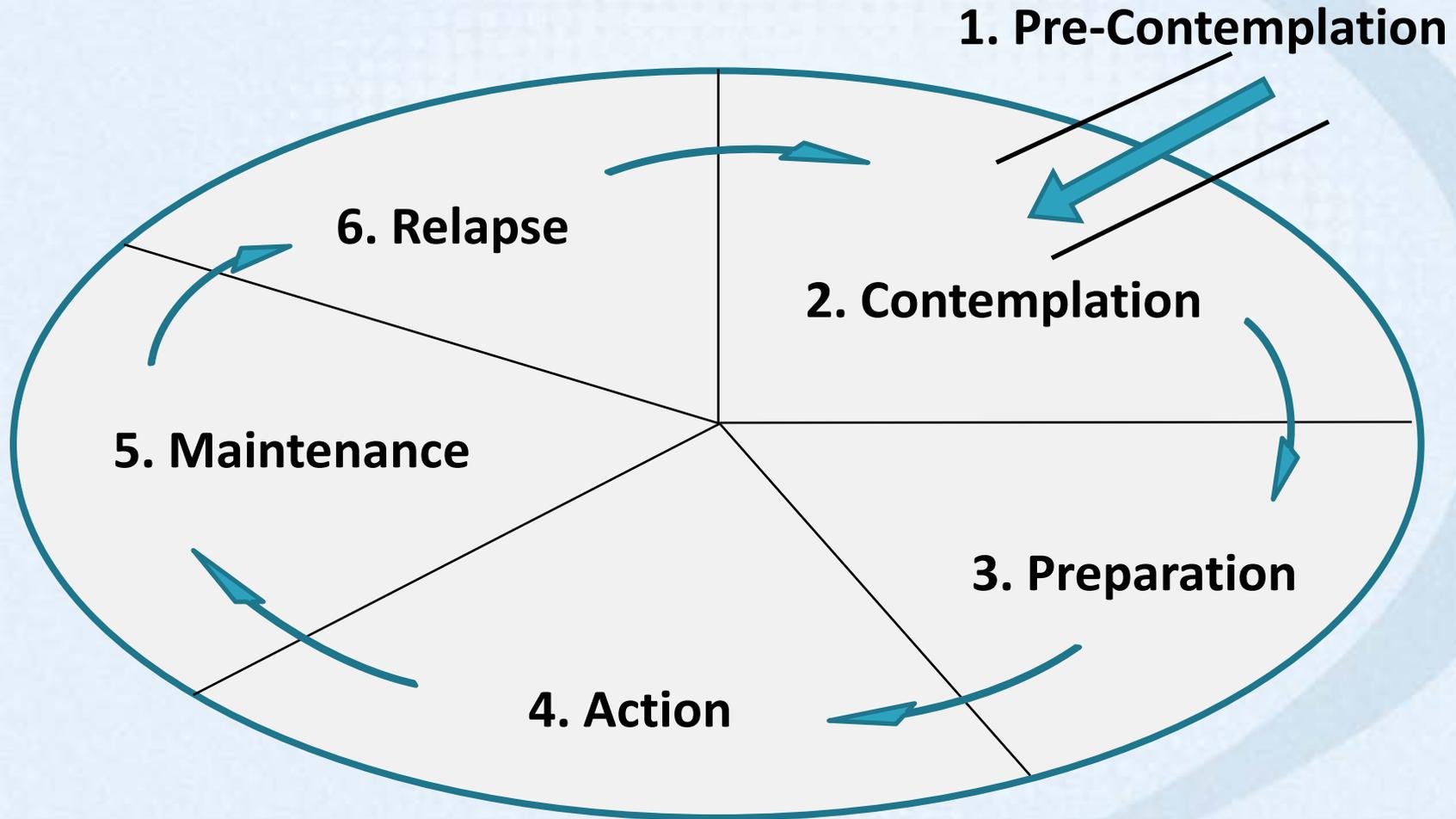


Based Treatment Improving
Veterans

Session 1

- ▶ Assess tobacco use, abstinence attempts, and reasons for quitting smoking
- ▶ Advise quitting
 - Use motivational interventions if necessary
- ▶ Orient to behavioral counseling
- ▶ Recommend smoking cessation medications
- ▶ Review guidelines for setting a quit date
- ▶ Coordinate care with prescriber
- ▶ Patient receives workbook

Stages of Change



Strategies for Dealing with Resistance: The 4 R's

- **Relevance** to particular smoker
 - Personalized reasons
- **Risks** of continued smoking
 - Personalized risks including acute, long term, environmental
- **Roadblocks** to quitting smoking
 - Identify and provide education regarding treatments that will help with obstacles
- **Repeat** motivational intervention at each clinic visit
 - Until willing to set a quit date or refuses stop smoking treatment

Session 2

- ▶ Identify quit date
- ▶ Coping skills for triggers
- ▶ Controlled breathing
- ▶ Identify existing patient-generated coping skills

Session 3

- ▶ Develop action plan for coping with smoking triggers
 - Triggers: environmental, thoughts, emotions, memories
- ▶ Review homework and use of smoking cessation medications
 - Assignment to practice coping with smoking triggers
 - Status of reduced smoking

Session 4

- ▶ Review assignment to practice coping with smoking triggers
- ▶ Behavior changes to prepare for quit date
- ▶ Identify sources of social support and how others will help the patient stop smoking
- ▶ Assign homework and discuss medications

Session 5

- Review assignment to practice coping with smoking triggers
- Review actions to take on quit date
- Review assignments to use social supports
- Introduction to relapse prevention
- Review plan for using smoking medications
- Schedule follow-up appointment

Follow-Up Visits

- ▶ Those who stop usually made six to eight quit attempts before achieving success
- ▶ For abstinent patients:
 - Support continued abstinence
 - Discuss positive experiences
 - Assess and resolve problems
- ▶ For patients who continued to smoke:
 - Renew commitment to abstinence
 - Set new quit date
 - Identify goals for next session
 - Schedule next follow-up visit

Brief Behavioral Counseling for Tobacco Cessation

- ▶ Brief interventions (The five As) can be used as alternative treatment for patients who cannot commit to integrated care
- ▶ Brief interventions can be followed by more intensive approach
- ▶ The five A's:
 - Ask about smoking status
 - Advise quitting
 - Assess willingness to quit
 - Assist quit efforts
 - Arrange follow-up

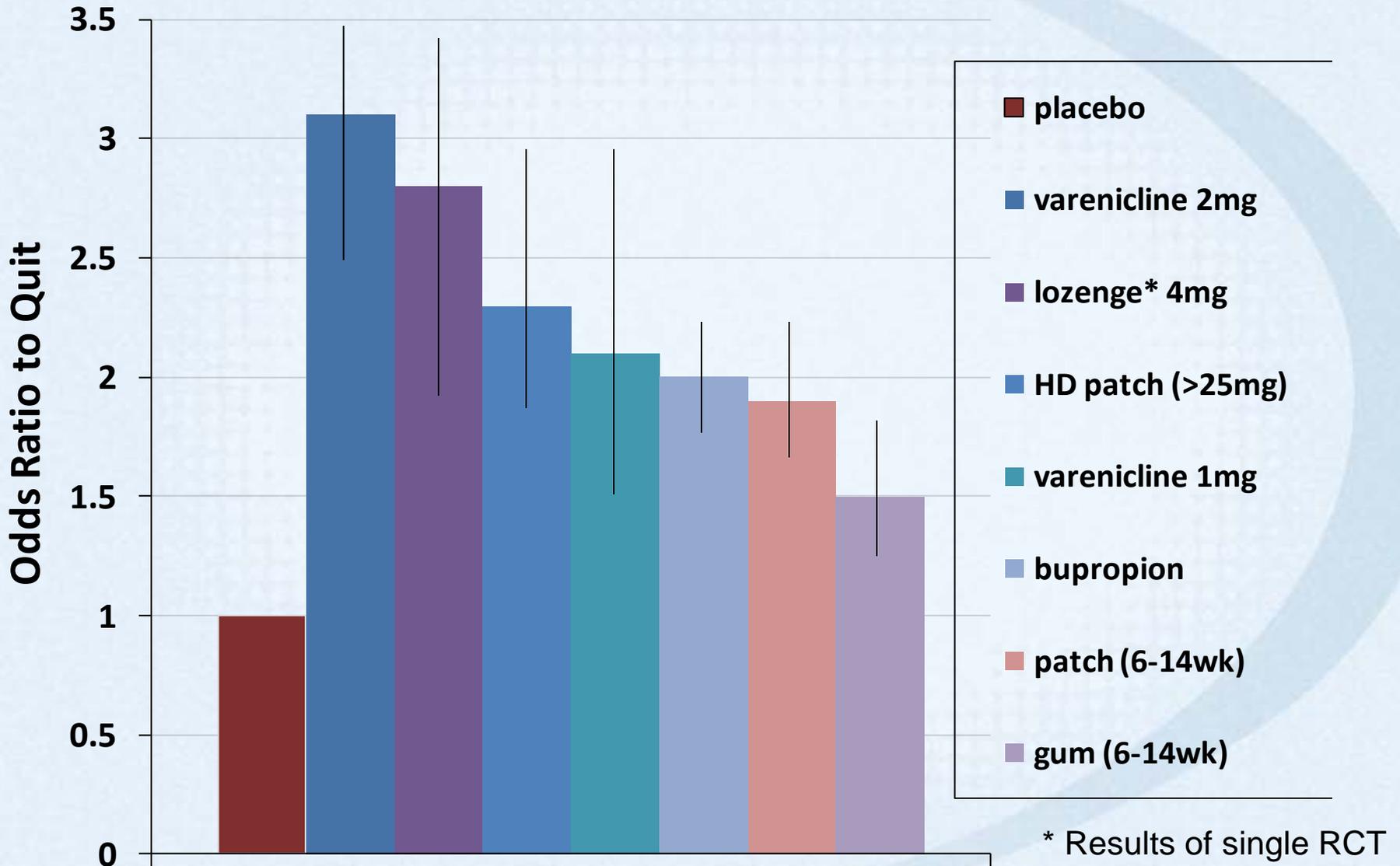
Pharmacotherapy

- ▶ Who Should Prescribe Medications?
 - PTSD clinical team prescriber
- ▶ Prescriber must have ability to coordinate tobacco use cessation medications with psychiatric medications

Clinical Practice Guidelines

- ▶ U.S. Public Health Service Clinical Practice Guideline for Treating Tobacco Use and Dependence – 2008 Updates
 - Reviews data from over 8,700 studies
 - Scope: clinical treatment of tobacco use and dependence
 - Ten key guideline recommendations
 - Seven address use of medication regarding tobacco use cessation (TUC)

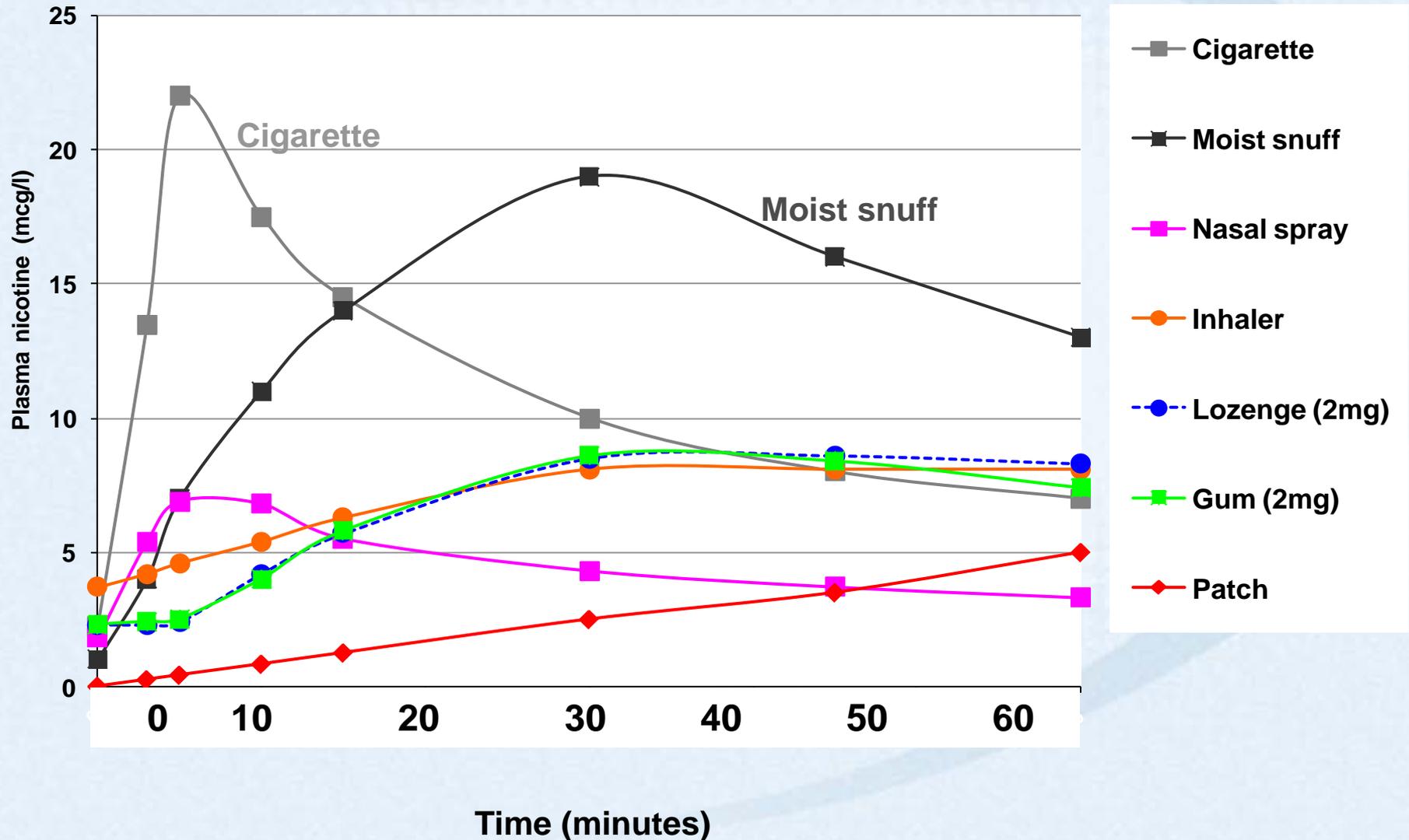
Effectiveness of Tobacco Use Cessation Medications (83 studies)



Nicotine Replacement Therapy (NRT)

- ▶ Slower onset: ↓ immediate reinforcing effects of tobacco
- ▶ ↓ Physical withdrawal symptoms
- ▶ Guidelines discuss dosing of various NRTs and techniques for instructing patients to use

NRT Plasma Nicotine Concentrations



Smoking Cessation Medications for Patients with PTSD

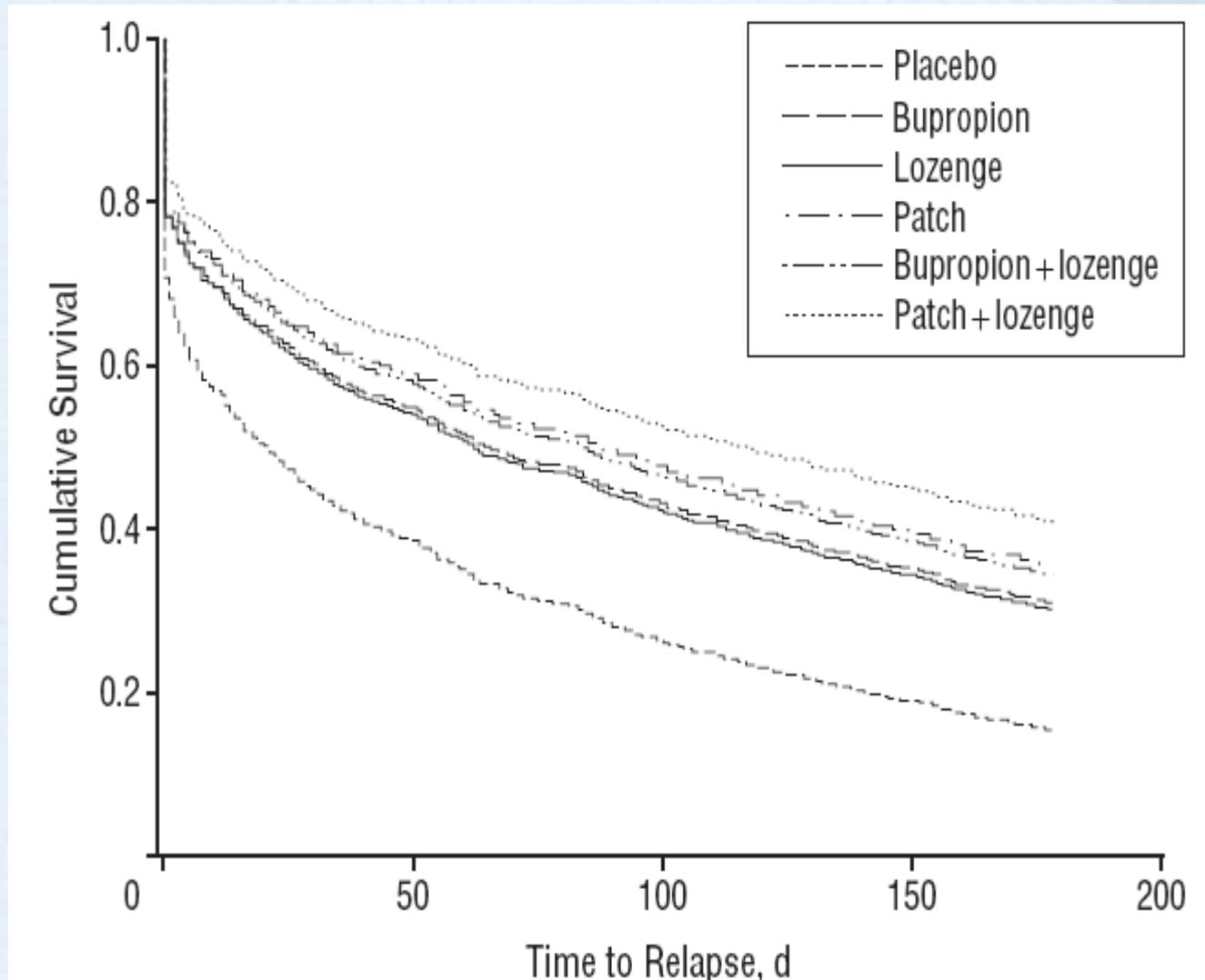
- Need aggressive pharmacotherapy
- Advantages to combining NRTs
- Bupropion and Varenicline
 - Psychiatric side effects, but should not prevent you from trying these medications

Varenicline and Suicidal Behavior

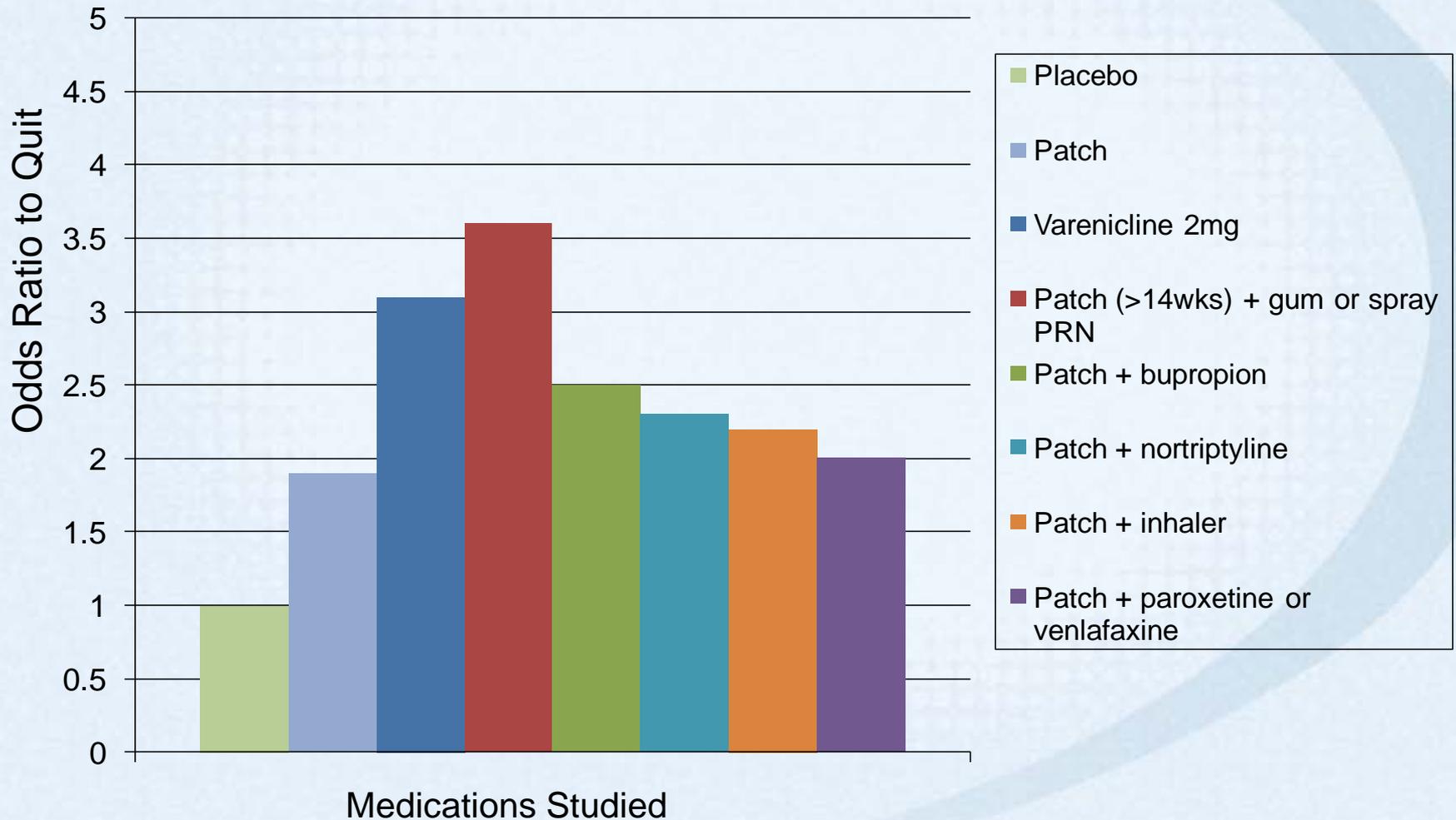
80,660 patients in UK starting smoking cessation therapies between 2006 and 2008

Smoking cessation product	No of events/No of people prescribed the product	Hazard ratio (95% CI)	
		Adjusted for age and sex	Fully adjusted†
Fatal and non-fatal self harm			
Nicotine replacement	141/63 265	1.0	1.0
Bupropion	9/6422	0.66 (0.33 to 1.29)	1.17 (0.59 to 2.32)
Varenicline	18/10 973	0.71 (0.43 to 1.16)	1.12 (0.67 to 1.88)
Suicidal thoughts			
Nicotine replacement	30/63 265	1.0	1.0
Bupropion	2/6422	0.69 (0.16 to 2.90)	1.20 (0.28 to 5.12)
Varenicline	5/10 973	0.94 (0.36 to 2.42)	1.43 (0.53 to 3.85)

Controlled Trial of 5 Pharmacotherapies



Effectiveness of Combination Therapies



Combination NRT: Dosing

- Nicotine patch:
 - Begin with 21mg or 14mg based on daily cigarette usage
 - Continue up to 18-24 weeks
- Adjunct NRT (e.g., nicotine gum, lozenge):
 - 12 pieces/lozenges/day PRN when acute withdrawal symptoms and urges to use tobacco occur
 - Continue between 26-52 weeks
- Adjust dose of patch if frequent use of adjunct NRT
 - Goal: minimize need for PRN dosing
- Longer durations indicated for heavier smokers or those having difficulty achieving abstinence

Long Term Treatment with NRT

2008 Guideline: “A minority of individuals who successfully quit smoking use ad libitum NRT medications (gum, nasal spray, inhaler) long-term. The use of these medications for up to 6 months does not present a known health risk, and developing dependence on medications is uncommon. Additionally, the FDA has approved the use of bupropion SR, varenicline, and some NRT medications for 6-month use.”

Common Question 1

I'm working with my patient on PTSD and alcohol use issues. Does it make sense to add smoking cessation as well?



Hear the Answer

Common Question 1

I'm working with my patient on PTSD and alcohol use issues.

Does it make sense to add smoking cessation as well?

- ▶ No evidence of risk for adding cessation treatment
- ▶ Also no harm in waiting

Common Question 2

When is the best time to offer smoking treatment when you are already doing a manualized treatment like Prolonged Exposure or Cognitive Processing Therapy?



Hear the Answer

Common Question 2

When is the best time to offer smoking treatment when you are already doing a manualized treatment like Prolonged Exposure or Cognitive Processing Therapy?

- ▶ No universal evidence-based answer
- ▶ Patient preference or what is negotiated between provider and patient
- ▶ Just remember to do it at some point
- ▶ Many Veterans prefer to do it after PE or CPT
 - That may increase the chances of quitting

Common Question 3

Incorporating smoking cessation treatments seems to take a lot of extra time. Can you really fit it into a one-hour session?



Hear the Answer

Common Question 3

Incorporating smoking cessation treatments seems to take a lot of extra time. Can you really fit it into a one-hour session?

- ▶ Depends on the nature of the treatment
- ▶ Might not fit in well to PE or CPT
 - Schedule additional time
- ▶ Might fit in during other forms of therapy
 - Carve out ~20 minutes for cessation treatment

Common Question 4

Can smoking cessation treatment be conducted in a group setting?



Hear the Answer

Common Question 4

Can smoking cessation treatment be conducted in a group setting?

- ▶ Yes, if time and resources do not allow individual modality, group-based treatment could be offered

Common Question 5

Why is it so important for the team psychiatrist to be involved in helping patients with tobacco cessation?

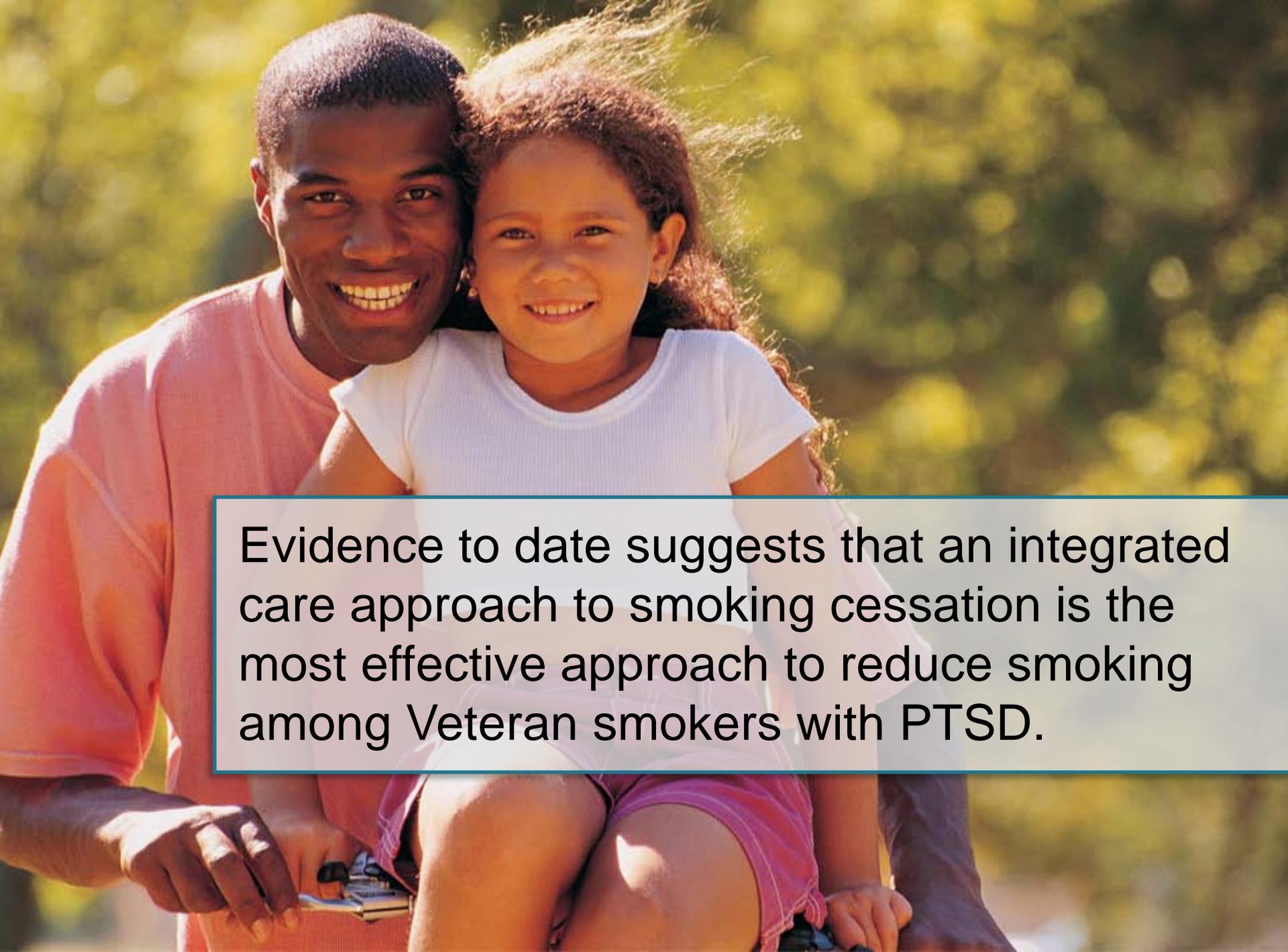


Hear the Answer

Common Question 5

Why is it so important for the team psychiatrist to be involved in helping patients with tobacco cessation?

- Vast majority of patients with PTSD will need smoking cessation medication
- They need the medication when they make the quit attempt
- Teamwork is critical

A photograph of a man and a young girl smiling together outdoors. The man is on the left, wearing a pink shirt, and the girl is on the right, wearing a white shirt. They are both looking towards the camera. The background is a blurred green and yellow, suggesting a park or natural setting. A semi-transparent text box is overlaid on the bottom right of the image.

Evidence to date suggests that an integrated care approach to smoking cessation is the most effective approach to reduce smoking among Veteran smokers with PTSD.

Providers Are Responsible to Help Veterans with PTSD Quit Smoking



Resources

- ▶ Information on VA clinical care topics:
<http://www.publichealth.va.gov/smoking/clinicaltopics.asp>
- ▶ U.S. Department of Health and Human Services Clinical Practice Guidelines for treating tobacco use and dependence:
http://www.surgeongeneral.gov/tobacco/treating_tobacco_use08.pdf
- ▶ Click the Attachments button at top right to access the following PDF downloads:
 - Presentation References
 - Patient Handout: Clearing the Air Patient Handbook
 - Patient Handout: Patient Coping Cards
 - Integrated Care Participant Workbook
 - Integrated Care Treatment Manual
 - Smoking Brief Treatment Guideline
 - VA Clinical Recommendations Flowcharts